

**DEPARTMENT OF INSURANCE
STATE OF ARIZONA**

Financial Affairs Division- Tax Unit
2910 North 44th Street, Suite 210
Phoenix, Arizona 85018-7269
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**2005 EXEMPT ACCOUNTABLE HEALTH PLAN
SMALL GROUP PREMIUM SCHEDULE**

COMPANY NAME _____ **NAIC NUMBER** _____

GENERAL INSTRUCTIONS

DO NOT COMPLETE AND FILE THIS SCHEDULE IF NO SMALL GROUP PREMIUM EXEMPTION IS CLAIMED

DO NOT COMPLETE AND FILE THIS SCHEDULE IF THE COMPANY HAS NOT RECEIVED APPROVAL FROM THIS DEPARTMENT AS AN ACCOUNTABLE HEALTH PLAN. SMALL GROUP PREMIUM EXEMPTIONS CLAIMED BY A COMPANY THAT IS NOT AN APPROVED ACCOUNTABLE HEALTH PLAN WILL BE DISALLOWED AND ADDITIONAL TAX, PENALTY AND INTEREST WILL BE ASSESSED.

LIST ONLY SMALL EMPLOYERS FOR WHICH THE COMPANY IS ABLE TO CERTIFY THAT:

1. The Small Employer is not a part of a larger, or statewide, or multi-state, or national employer entity that has additional employees at any other location within Arizona or outside of the State of Arizona.
2. The number of Eligible Employees that have been verified and reported for the Small Employer includes all employees that are eligible to participate in the Health Benefits Plan issued to the Small Employer and is not limited to employees actually participating in the Plan.
3. The Company has established methods and procedures to assure that the Small **Employer continues to qualify** as a Small Employer on an ongoing basis.
4. The Small Employer had a **minimum of 2 and not more than 50 Eligible Employees on a typical business day** during any one calendar year.

PART A – DESCRIPTION OF METHODS EMPLOYED FOR COMPLIANCE

In the space below, **describe the methods used by the Company to affirm initial and continued qualification** of Small Employers whose premiums are being claimed as exempt from tax. **Attach samples of documentation relied upon and retained by the Company to support the premiums claimed as exempt from tax.** *Please note that Small Group premiums claimed as exempt are subject to audit and supporting records are subject to examination by this Department. Failure to provide adequate samples of documentation may result in disallowance of claimed exemptions and assessment of tax, penalty and interest, accompanied by a Notice of Right of Appeal.*

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and extend across the width of the page. There are no margins, text, or other markings on the paper.

Print or Type Preparer's Name _____

Phone Number

E-mail Address

PART B – LIST OF QUALIFIED SMALL EMPLOYERS AND EXEMPT PREMIUMS

COMPANY NAME _____ **NAIC NUMBER** _____

Please provide the following information to us on a **clearly labeled CD-Rom** with data in **MS EXCEL**, in **IDENTICAL FORMAT**. You must file this form and show the total exempt premiums claimed in the box below.

Provide:

- The **COMPLETE NAME** of each Small Employer.
- The **ARIZONA city or town** where each Small Employer is located.
- For each **NEW (in 2005) Small Employer**, the **# of ELIGIBLE Employees at Policy Inception Date**.
- For each **RENEWED (in 2005) Small Employer**, the **# of ELIGIBLE Employees at Policy Renewal Date**.
- **FOR EVERY SMALL EMPLOYER** listed, the date that the Company last verified qualification as a Small Employer in accordance with the method(s) described in Part A for affirming continued qualification.
- For every Small Employer, the total amount of **Exempt Premiums** claimed.
- Enter the **sum of all Exempt Premiums Claimed in the TOTAL line**.

ENTER FOR ALL		FOR NEW POLICY ONLY	FOR POLICIES RENEWED IN 2005 ONLY		ENTER FOR ALL	
Complete Name of Small Employer	Arizona City or Town Where Employer is Located	# of <u>Eligible</u> Employees on Policy Inception Date	# of <u>Eligible</u> Employees on Renewal Date	Policy Renewal Date	Date Small Employer Qualification Last Verified in 2005	Exempt Premium Amount Claimed
1						\$
2						\$
3						\$
4						\$
5						\$
6						\$
7						\$
8						\$
9						\$
10						\$
11						\$
12						\$
13						\$
14						\$
15						\$
TOTAL: Enter the sum of Lines 1 through 15 (or of all attached pages) here and on the applicable tax report: Form E-ANNUALTAX - Page 2, Line 6b, Column 1 or Column 2 Form E-HEALTHORG - Page 2, Lines 1 and 2, Column C						\$

ATTACH THIS SCHEDULE TO FORM E-ANNUALTAX OR FORM E-HEALTHORG